

CONTENTS

	Page
Recommendations of the Committee	
Purpose and Summary	
Background and Need for Legislation	
Hearings	
Committee Consideration	
Committee Votes	
Committee Oversight Findings	
Statement of General Performance Goals and Objectives.....	
New Budget Authority, Entitlement Authority, and Tax Expenditures.....	
Committee Cost Estimate	
Congressional Budget Office Estimate	
Federal Mandates Statement.....	
Advisory Committee Statement	
Constitutional Authority Statement.....	
Applicability to Legislative Branch	
Section-by-Section Analysis of the Legislation	
Changes in Existing Law Made by the Bill, as Reported.....	
Dissenting Views	

RECOMMENDATIONS OF THE COMMITTEE

[Insert text of Committee Print here]

PURPOSE AND SUMMARY

The purpose of this Committee Print is to implement much needed Medicaid reforms. This Committee Print also complies with the reconciliation directive included in section 201 (a) of the Concurrent Resolution on the Budget for Fiscal Year 2006, H.Con.Res. 95, and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

BACKGROUND AND NEED FOR LEGISLATION

Medicaid currently provides medical care to 53 million Americans at a cost exceeding \$300 billion. According to the Centers for Medicare and Medicaid Services (CMS), total combined Federal and state spending on Medicaid over the next 10 years is estimated at \$4.5 trillion. Medicaid is already the biggest item in many state budgets, exceeding elementary and secondary education combined.

The Medicaid program is a shared responsibility of Federal and state governments to provide medical assistance to certain low-income groups. State expenditures are matched by the Federal government using a formula based on average per capita income in each state relative to national per capita income. The Federal Medical Assistance Percentage (FMAP) for fiscal year 2006 will range from 50 to 76%. Overall, the Federal government pays for about 57% of total Medicaid expenditures.

Unlike the Federal government, states can not have deficits, so the only way for governors to meet their Medicaid obligations is to either raise taxes or cut benefits. Unreformed, analysts predict Medicaid will

bankrupt every state in as little as 20 years—absorbing 80-100% of all state dollars.

States are already taking drastic action to avoid financial ruin. Between 2002 and 2005, all states reduced provider rates and implemented drug cost controls; 38 states reduced eligibility; and 34 states reduced benefits. Hundreds of thousands of beneficiaries are already slated to lose eligibility or face reduced benefits in several states.

In response to this crisis, the National Governors Association (NGA) has put forth a bipartisan Medicaid reform plan developed by an NGA working group of eleven governors; nine of whom serve on the NGA's Executive Committee. The working group began deliberating late last year and received input from Medicaid directors and governors from more than 30 states. The NGA supports both short-term flexibilities and long-term structural reform to promote quality care and sustainability of the program. Among others, reforms are recommended in key areas such as the Medicaid prescription drug reimbursement, asset transfers, cost sharing, and benefit package flexibility.

Medicaid has unquestionably succeeded in its basic mission of providing health care coverage for vulnerable, low-income populations. At the same time, its structure contains flaws that have led to serious problems, some of which have impeded Medicaid recipients' ability to access quality health care. Medicaid now covers many diverse populations that differ substantially from the very low-income persons the program was initially designed to cover. The program still, however, applies many of the original eligibility and benefit mandates to all of these populations. In addition, the Medicaid program also imposes a standard limitation on recipient cost-sharing, irrespective of a person's income level. Some have suggested the possibility of improving Medicaid's program design by allowing different populations to have access to multiple packages of benefits, along with cost-sharing obligations that reflect their different income levels, that would be better tailored to their individual needs.

Many Medicaid recipients currently are unable to obtain quality health care services because they have little autonomy in making their health care decisions. They are limited to those providers that a state selects, who are willing to accept the reimbursement amounts set by the state. This often results in beneficiaries having little or no input into what services they receive, who provides those services, and when they can receive them. A limited number of states operating under research and demonstration waivers, authorized under Section 1115 of the Social Security Act, are currently participating in projects that allow certain disabled Medicaid recipients to exercise greater control over their health care services. These demonstrations provide cash allowances to these Medicaid recipients, and allow them to purchase their necessary services, while providing them with assistance in managing their funds. These demonstrations have proven to be extremely popular among the disabled Medicaid recipients that participated in the programs.

As previously noted, Medicaid also faces a looming crisis, due to the projected increases in costs associated with long-term care. Many advocates believe that the current Medicaid reimbursement structure reflects a strong bias towards providing long-term care in institutional

settings, which is less preferable for many recipients and is often more expensive than other care options. In addition, Medicaid's current benefit structure often encourages seniors with higher incomes to engage in creative estate management and asset redistribution, to enable them to qualify for the long-term care benefits that Medicaid provides, rather than encouraging more of them to purchase private long-term care insurance.

During the 108th and 109th Congresses, the House Committee on Energy and Commerce held ten hearings on the topic of reforming the Medicaid program. These hearings highlighted the need for reform and illustrated several areas of specifically needed reforms.

Hurricanes Katrina and Rita severely disrupted crude oil and natural gas production in the Gulf of Mexico. They also shut down most of the crude oil refinery capacity in the Gulf of Mexico region. These production and supply disruptions are expected to lead to increased home energy costs this winter. The Energy Information Administration projects that average home heating expenditures will increase about 33% this winter, assuming a normal winter. Expenditures for natural gas and home heating oil may increase significantly more. Disruptions to fuel supplies may lead to higher fuel costs throughout the year, impacting both heating and cooling costs. These large increases in costs will particularly harm low-income consumers. The Low-Income Home Energy Assistance Program ("LIHEAP") is designed to help low-income Americans with heating and cooling costs. Accordingly, Congress seeks a one-time only supplement to LIHEAP funds to assist low-income consumers with the higher home energy bills they will see as a result of Hurricanes Katrina and Rita.

HEARINGS

The Full Committee and the Subcommittee on Health held hearings on Medicaid reform during the first session of the 109th Congress. On April 27, 2005, the Subcommittee on Health held a hearing entitled "Long-Term Care and Medicaid: Spiraling Costs and the Need for Reform." The Subcommittee received testimony from Dr. Mark McClellan, Administrator of the Centers for Medicare & Medicaid Services (CMS); Dr. Douglas Holtz-Eakin, Director of the Congressional Budget Office (CBO); Kathy Allen, Director, Health Care, Medicaid and Private Health Insurance Issues, U.S. Government Accountability Office (GAO); Carol O'Shaughnessy, Specialist in Social Legislation, Congressional Research Service (CRS); Karen Ignani, President & CEO, America's Health Insurance Plans; Stephen Moses, President, Center for Long-Term Care Financing; Dr. Barbara Stucki, National Council on Aging; Bernard Krooks, Esq.; Jennie Chin Hansen, Board Member, AARP; Judy Feder, Dean of Public Policy, Georgetown University; and, Lee Page, Associate Advocacy Director, Paralyzed Veterans of America.

On June 15, 2005, the Full Committee held a hearing entitled "Medicaid Reform: the National Governors Association's Bipartisan Roadmap." The Committee received testimony from NGA Chairman, Virginia Gov. Mark Warner and NGA Vice-Chairman, Arkansas Gov. Mike Huckabee.

On June 22, 2005, the Subcommittee on Health held a hearing entitled: "Medicaid Prescription Drugs: Examining Options for Payment Reform." The Subcommittee received testimony from Dr. Douglas Holtz-Eakin, Director of the Congressional Budget Office (CBO); Mr. Anthony Rodgers, Director of the Arizona Medicaid program; Craig Fuller, Vice-President of the National Association of Chain Drug Stores (NACDS); John Calfee, Resident Scholar at the American Enterprise Institute (AEI); Kathy King, U.S. Government Accountability Office (GAO); and, Kathleen Gifford, Health Management Associates.

On September 8, 2005, the Full Committee held a hearing entitled: "Medicaid: Empowering Beneficiaries on the Road to Reform." The Committee received testimony from Mr. Jim Gardner, President & CEO Northeast Georgia Health System; Mr. David Parrella, Director, Connecticut Medical Care Administration; Mr. Merrill Mathews, Executive Director, Council for Affordable Health Insurance; The Honorable Frank Keating, President & CEO, American Council of Life Insurers; Dr. David Alexander, President, DeVos Children's Hospital; Dr. Thomas "Byron" Thames representing AARP; and, Mr. Bob Sheehan, Executive Director, Community Mental Health Authority of Clinton-Eaton-Ingham Counties.

COMMITTEE CONSIDERATION

On Wednesday, October 27, 2005, the Committee met in open markup session and approved the Committee Print entitled Medicaid, Katrina Health Care Relief, and Katrina and Rita Energy Relief, amended, by a record vote of 28 yeas and 22 nays. A motion by Mr. Barton to transmit the recommendations of the Committee, and all appropriate accompanying material including additional, supplemental, or dissenting views, to the House Committee on the Budget, in order to comply with the reconciliation directive included in section 201 (a) of the Concurrent Resolution on the Budget for Fiscal Year 2006, H.Con.Res. 95, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974, was agreed to by a voice vote.

COMMITTEE VOTES

Clause 3(b) of Rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on amendments offered to the measure, including the names of those Members voting for and against. A motion by Mr. Barton to transmit the recommendations of the Committee, and all appropriate accompanying material including additional, supplemental, or dissenting views, to the House Committee on the Budget, in order to comply with the reconciliation directive included in section 201 (a) of the Concurrent Resolution on the Budget for Fiscal Year 2006, H.Con.Res. 95, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974, was agreed to by a voice vote.

[Insert Votes Here]

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of Rule XIII of the Rules of the House of Representatives, the Committee held oversight hearings and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

This legislation will reform Medicaid to provide for the long term sustainability of the program, and for other purposes.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of Rule XIII of the Rules of the House of Representatives, the Committee adopts as its own estimate prepared by the Director of the Congressional Budget Office concerning new budget authority. This estimate is done to comply with the reconciliation directive included in section 201 (a) of the Concurrent Resolution on the Budget for Fiscal Year 2006, H.Con.Res. 95, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of Rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

[Insert CBO estimate here]

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of Rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 3100. Short title of subtitle; rule of construction with regard to Katrina evacuees.

Section 3100 establishes the short title of the subtitle as “Medicaid Reconciliation Act of 2005.” The section also establishes a rule of construction with regard to Hurricane Katrina evacuees.

Section 3101. Federal upper limit (FUL).

Current Law

Under current law, states have considerable flexibility in setting the Medicaid payment rates for prescription drugs. However, total Federal reimbursements for state prescription drug spending are subject to a ceiling called the Federal upper limit (FUL).

The FUL applies to multiple source drugs — those that have at least three therapeutically equivalent drug versions sold by at least three suppliers. The FUL is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale prices (AWP) for each group of drug equivalents. The FUL amounts are calculated and published in regulations by CMS. CMS

periodically updates the FUL list and re-publishes those amounts. A state's payment for all Medicaid prescription drugs with a FUL must not exceed, in the aggregate, the payment levels established by the FUL program. The aggregate cap allows states to increase or decrease the cost of individual prescription drugs in accordance with state or local markets while maintaining the overall savings created by the FUL program. States may exceed the FUL price for individual prescription drugs as long as their aggregate expenditures do not exceed the amounts that would have otherwise been spent by applying the FUL limit plus a reasonable dispensing fee.

Pharmaceutical manufacturers that wish to have their products available to Medicaid beneficiaries must enter into "rebate agreements" under which they agree to provide state Medicaid programs with the rebates based on drugs provided to Medicaid beneficiaries. The rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain products, the best price at which the manufacturers sells the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies and must be provided by manufacturers to CMS through routine reporting and periodic verification surveys.

AMPs and best prices, as submitted by prescription drug manufacturers to CMS for the purpose of calculating Medicaid drug rebates, must remain confidential except as the Secretary determines necessary to carry out the Medicaid prescription drug provisions, and to permit the Comptroller General and the Congressional Budget Office to review the information provided.

Explanation of Provision

Medicaid prescription drug coverage is one of the most expensive and fastest growing health care expenditures. In fiscal year (FY) 2003, Medicaid prescription drug expenditures totaled \$31 billion, triple what was spent in 1994. Between 1998 and 2002, Medicaid prescription drug expenditures grew at an annual rate of 19 percent, and the Office of the Actuary at CMS projects an annual growth rate of 12.7 percent through 2011. That is a far higher rate of growth than overall Medicaid expenditures.

While prescription drugs expenditures are rapidly rising, it is also becoming evident that AWP does not reflect prices that are actually paid in the marketplace. In December, 2004, the Committee on Energy and Commerce held a hearing, "Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much." In that hearing, HHS Assistant Inspector General (IG), George Greeb, testified that, "the published AWP that States use to establish their Medicaid drug reimbursements generally bear little resemblance to the prices incurred by retail pharmacies to purchase drugs." Additionally, the IG discovered that pharmacy acquisition costs for brand name drugs in 1999 were an average of 21.8% below AWP and for generic drugs were an average of 65.9% below AWP.

Section 3101 would replace the current FUL requirement that is based on AWP with a new FUL formula based on retail average manufacturer price (RAMP).

FUL for Ingredient Cost

The FUL for the ingredient cost of a single source drug would be equal to the 106% of the retail average manufacturer price (RAMP) for that drug. The FUL for the ingredient cost of a multiple source drug would be equal to 120% of the volume weighted average RAMP for that drug.

RAMP is based on AMP and defined as the average price paid to a manufacturer for the drug in the U.S. in the quarter by wholesalers for drugs distributed to retail pharmacies, excluding service fees paid by the manufacturer. Sales exempted from RAMP would include those sales exempt from the determination of best price and any other sales as identified by the Secretary that are nominal in amount. In calculating RAMP, cash and volume discounts; free goods contingent upon a purchase requirement; nominal price sales contingent upon a purchase requirement or agreement; chargebacks and rebates provided to a pharmacy or any other direct or indirect discounts; and any other price concession, which may be based on the recommendation of the Inspector General of HHS, that result in a reduction of cost to the purchaser would be included. Under this subsection, retail pharmacies would be defined to exclude mail-order only pharmacies and pharmacies at nursing facilities and homes.

With respect to “free goods contingent upon a purchase requirement or agreement” referred to above, the Committee intends to ensure consistent treatment to other Federal programs of the terms used in the RAMP methodology. For example, the terms “free goods not contingent on a purchase” should also include free drugs that are provided to induce a contemporaneous or a future purchase of the same or another drug. The terms “free goods not contingent on a purchase” should, for Medicaid, have the same meaning as the terms are used in Medicare.

The volume weighted RAMP would be determined, for all drug products included within the same multiple source drug billing and payment code. The RAMP for each product with a National Drug Code (NDC) would be multiplied by the total number of units of the drug product sold, and then those amounts would be summed together and divided by the total number of units sold for all NDC codes.

For drugs sold during an initial sales period in which data on sales for the drug is not sufficiently available from the manufacturer to compute the RAMP or the weighted average RAMP, the provision would establish a transitional upper payment limit to apply only during such period. During the initial sales period, not to exceed 2 calendar quarters, the upper limit for such drugs would be calculated to be equal to the wholesale acquisition cost (WAC) for the drug. The provision would define WAC to be the manufacturer’s list price for the drug or biological to wholesalers or direct purchasers in the U.S., not including prompt pay or other discounts, rebates or reductions in price, for the most recent

month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

The Secretary would be required to update the upper payment limits on a quarterly basis, taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's (FDA) most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations." In addition, the Secretary would be required to collect data on the price and volume of sales of covered outpatient drugs for the first calendar quarter beginning after the date of enactment or during which the drug is marketed, whichever is later.

States may elect not to apply the new FUL to covered outpatient drugs dispensed by specialty pharmacies as defined by the Secretary, or drugs administered by a physician in a physician's office. Certain drugs administered in specialty pharmacies and physician's offices, may require additional administrative expenses, and thus the appropriate payment level may exceed the FUL.

Dispensing Fees

Section 3101 would require states to pay a dispensing fee for each covered outpatient drug. Dispensing fees for drugs defined as multiple source drugs under the FUL policy would be required to be no less than \$8 per prescription unit. The Secretary would be required to define what constitutes a prescription unit for this purpose. Additionally, this section explicitly states that states would be allowed to vary dispensing fees to take into account the special circumstances of pharmacies serving rural and underserved areas and sole community pharmacies. This section did not set a dispensing fee level for single source drugs, so that the setting of such fees remains at the state's discretion.

Evaluation of Use of Retail Survey Price Methodology

Section 3101 would allow the Secretary to develop a methodology to set the FUL based on the most recently reported retail survey price instead of a percentage of RAMP or the volume weighted average RAMP. For 2007, the Secretary may use this methodology for a limited number of covered outpatient drugs, including both single source and multiple source drugs selected to be representative of the classes of drugs dispensed under Medicaid.

The provision would allow the Secretary to contract with a vendor to obtain retail survey prices for Medicaid covered outpatient drugs that represent a nationwide average of pharmacy sales costs for such drugs, net of all discounts and rebates. Such a contract would be awarded for a term of 2 years. The Secretary would be required to (1) competitively bid for an outside vendor with a demonstrated history in surveying and determining on a representative nationwide basis, retail prices for ingredient costs of prescription drugs; (2) work with retail pharmacies, commercial payers, and states in obtaining and disseminating price information; and, (3) collect and report price information on at least a monthly basis. The contract would include the terms and conditions

specified by the Secretary and would include a requirement that the vendor (1) monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug available nationwide; (2) update the Secretary no less often than monthly on the retail survey prices for multiple source drugs and on the computed upper payment limit for those drugs; and, (3) to independently confirm retail survey prices. Information on the retail survey prices obtained through this process, including information on single source drugs would be required to be provided to states on an ongoing and timely basis.

The provision would also require the Secretary to devise and implement a means for electronic distribution of the most recently calculated AMP and retail survey price for single source drugs, and the most recently calculated AMP and FUL for multiple source drugs to each state Medicaid agency. States would be permitted to use such data in establishing payment rates for ingredients and dispensing fees for covered outpatient drugs under state Medicaid programs. The provision would establish an additional exception to the confidentiality provision, allowing for states to use this price information in establishing payment rates.

Reports

Section 3101 would require the Comptroller General of the U.S. to provide a report to Congress no later than nine months after the date of enactment on the appropriateness of payment levels to pharmacies for dispensing fees under the Medicaid program. Within the report, the appropriateness in payments for pharmacies in rural or underserved areas, as well as specialty pharmacies, should be examined.

This provision would also require the Inspector General of HHS to provide a report to Congress, no later than two years after the date of enactment, on the appropriateness of using RAMP and retail survey prices rather than the AMP or other price measures, as the basis for establishing a FUL for reimbursement of outpatient drugs under Medicaid.

Section 3102. Collection and submission of utilization data for certain physician administered drugs.

Current Law

Manufacturers are required to provide rebates to states for all Medicaid covered outpatient prescription drugs, with a few exceptions. Managed care organizations as well as outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. States have often been unable to collect rebates on certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, because health providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectable prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide states with the specific manufacturer information necessary to

enable them to seek rebates. CMS has requested that states identify Medicaid drugs, specifically those billed using HCPCS J-codes, so that rebates can be collected for these drugs.

Explanation of Provision

CMS believes that because of this coding discrepancy, rebates have not been collected on these drugs, resulting in the loss of millions of dollars. Section 3102, states would be required to submit to the Secretary utilization data and coding information for single source drugs or biologicals that are physician administered outpatient drugs and are administered on or after January 1, 2006, so that the Secretary would be able to collect rebates for those drugs.

The Secretary would also require that no later than January 1, 2007, utilization data and coding information by NDC would be required for multiple source drugs (unless the Secretary identifies an alternative methodology. When the Secretary obtains that data, the Secretary would be required to publish a list of the 20 highest volume physician administered multiple source drugs. On or after January 1, 2008, the state would be required to submit utilization and coding information for the 20 highest volume drugs. The Secretary would be able to modify such list from year to year to reflect changes in such volume.

Under this section, states must submit this coding and utilization data as a condition of receiving Federal Medicaid payments. The Secretary may delay the application of the reporting requirements in the case of a state to prevent hardship to States that require additional time to implement such a reporting system.

Section 3103. Improved regulation of drugs sold under a new drug application approved under Section 505(c) of the Federal Food, Drug, and Cosmetic Act.

Current Law

Under the Medicaid drug rebate program, rebate amounts are calculated separately for brand name drug products provided to Medicaid beneficiaries and for generics. The rebate for brand name drugs, referred to as single source and innovator multiple source drugs, is equal to the greater of 15.1% of the average manufacturer's price (AMP) or the AMP minus the best price available from the manufacturer. The rebate for multiple source drugs is equal to 11% of the AMP.

Prescription drug manufacturers participating in the Medicaid program are required to report to the Secretary data on the AMP for each pharmaceutical product offered under Medicaid and, for each brand name drug product, the best price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term 'best price' is defined in the Medicaid statute but only with respect to brand name drugs since the best price is part of the rebate computation for only those drugs.

Drug price reporting is based on each drug product's unique "national drug code" (NDC). For each product for which pricing has

been reported, HHS calculates the rebate amount. The NDC code numbers are assigned to each drug product by the Food and Drug Administration (FDA) together with the manufacturers.

Sometimes manufacturers produce both a brand name version of a prescription drug and also sell or license a second manufacturer (or a subsidiary) to produce some of the same product to be sold or re-labeled as a generic. These generics, known as “authorized generics,” are sometimes distributed the same manufacturer and sometimes by a second manufacturer and are provided with a separate NDC code. The rebate is calculated for each manufacturer’s product and, for brand name products, takes into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic both because it is considered a separate product (with its own unique NDC number) and is often sold by a separate manufacturer.

Explanation of Provision

Section 3103 would modify the existing drug price reporting requirements for pharmaceutical manufacturers. Not later than 30 days after the last day of each rebate period, manufacturers would be required to report each covered outpatient drug, including those sold under a new drug application approved by the FDA, the average manufacturer’s price for such drugs; and, for single source drugs, innovator multiple source drugs, and any other drug sold under a new drug application approved by the FDA, the manufacturers best price for such drugs during the applicable rebate period; and not later than 30 days after the date of entering into a drug rebate agreement, on the average manufacturer price for each of the manufacturer’s covered outpatient drugs, including those sold under a new drug application approved by the FDA.

The current law definition of best price would be changed to apply not only to each single source drug and innovator multiple source drug, but also to drugs sold under a new drug application (NDA) approved by under Section 505(c) of the Federal Food, Drug and Cosmetic Act (FFDCA). In addition, the definition would be modified so that the best price, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity except for those entities excluded under current law.

Section 3103 would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits a drug of the manufacturer to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs.

Section 3103 would become effective on the date of enactment.

Section 3104. Children’s hospital participation in Section 340B drug discount program.

Current Law

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. This program limits the cost of covered outpatient drugs to certain Federal grantees, Federally-qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

Explanation of Provision

Under current law, while the 340B Drug Pricing Program is codified in the Public Health Service Act, the authority for the level of drug reimbursements is under Medicaid. Section 3104 amends the Section 1927(a)(5)(B) of the Medicaid statute to include children's hospitals (as described in Section 1886(d)(1)(B)(iii) of the Social Security Act) in the definition of "covered entity" to permit those hospitals access to 340B drug prices.

Section 3105. Improving patient outcomes through greater reliance on science and best practices.

Current Law

In general, Medicaid beneficiaries receiving care in the fee-for-service sector are assured of broad pharmaceutical coverage due to statutory requirements within the rebate agreements between states and the drug manufacturers. In return for entering into agreements with the Secretary, state Medicaid programs are required to cover all of the drugs marketed by those manufacturers (with possible exceptions for the categories of drugs that states are allowed to exclude from coverage).

Currently, states do have a number of techniques to control cost and utilization of pharmaceuticals. One of those techniques is prior authorization. Prior authorization is the requirement that only pharmaceutical products for which advance approval is sought and received from a designated individual or entity are to be covered. States may establish prior authorization programs under Medicaid for all drugs or for certain classes of drugs, as long as these programs meet two criteria: (1) they must respond within 24 hours to a request for approval, and (2) they must dispense at least a 72-hour supply of a covered drug in emergency situations. In 2002, all (including the District of Columbia) but four states report having a prior authorization procedure for at least some covered drugs.

Explanation of Provision

Section 3105 would require that an atypical antipsychotic or antidepressant single source drug may be subject to prior authorization only when a drug use review board has determined, based on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data and other information as the board determines to be

appropriate, that placing the drug on prior approval or otherwise imposing restrictions on its use is not likely to harm patients or increase overall medical costs. Additionally, if a response is not received for an atypical antipsychotic or antidepressant drug prescribed within 24 hours after the prescription is transmitted, payment is made for a 30 day supply of the medication.

Section 3105 would take effect January 1, 2007.

Section 3111. Lengthening Look-Back period; change in beginning date for period of ineligibility.

Current Law

The ability of individuals to transfer or shelter assets in order to meet Medicaid's financial eligibility requirements for long-term care services is well known. Countless books, seminars, advertisements, and billboards tout the services of professional "Medicaid planners" who assist seniors, often at the behest of adult children, with such "Medicaid estate planning" or "Medicaid planning" activities. A myriad of legal maneuvers and financial instruments, including large dollar annuities, are employed in this endeavor. In many instances, those who engage in Medicaid planning could have used at least a portion of transferred or sheltered assets to pay privately for long-term care—delaying or even obviating the need for taxpayer-financed care. While the precise extent of Medicaid planning is difficult to determine, it cannot be disputed that substitution of Medicaid dollars for otherwise available private dollars results in additional costs to the program. According to the Congressional Research Service, "even if only a fraction of spending were saved, it could be millions or possibly billions of dollars." (Medicaid Asset Transfers and Estate Planning, Testimony before the Senate Committee on Finance, June 19, 2005).

Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value. Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. Although there is no limit to the length of a penalty period, most penalty periods expire before care is ever needed thus rendering the notion of a penalty meaningless in such cases.

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue

hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and, (3) a process under which an adverse determination can be appealed.

Explanation of Provision

Section 3111 (a) would amend section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the general look-back date to 60 months (as is already the case with certain trusts) for income and assets disposed of by the individual after this Act's date of enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply.

Section 3111 (b) would amend section 1917(c)(1)(D) of the Social Security Act by changing the start date of the ineligibility period for all transfers made on or after the date of the enactment, to the first day of a month during or before which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the state plan and is receiving certain long-term care services, whichever is later and which does not occur during any period of ineligibility as a result of an asset transfer policy. These services would include (1) nursing facility care; (2) services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; (3) Section 1915(c) home and community-based waiver services; (4) home health services; and, (5) personal care furnished in a home or other locations. At state option, they may also include other state plan long-term care services.

The amendments made by this subsection would apply to transfers made on or after the date of enactment.

Section 3111 (d) specifies the criteria by which an application for an undue hardship waiver would be approved by codifying CMS guidance on state procedure. Approval would be subject to a finding that the application of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered, or that the individual would be deprived of food, clothing, shelter, or other necessities of life. States would also be required to provide for (1) notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and, (3) a process under which an adverse determination can be appealed.

This subsection would also amend section 1917(c)(2) of the Social Security Act to permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Section 3112. Disclosure and treatment of annuities and of large transactions.

Current Law

CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal), i.e., the annuity must be "actuarially sound." The purchase of an "actuarially sound" annuity by an applicant or a community spouse is a common technique to convert countable resources into non-countable income or income able to be sheltered for purposes of the Medicaid eligibility determination. It is not unusual for hundreds of thousands of dollars to be converted in this manner. Thus, individuals with significant assets can qualify for taxpayer-financed long-term care services virtually overnight.

Explanation of Provision

Section 3112 would amend section 1917 of the Social Security Act by adding a new subsection that would require individuals, at the initial application or recertification for certain Medicaid long-term care services, to disclose to the state the following:

- (A) A description of any interest the individual or community spouse has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a noncountable assets, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset;
- (B) Full information (as specified by the Secretary) concerning any transaction involving the transfer or disposal of assets during the previous 60 month period, if the transaction exceeded \$100,000, without regard to whether the transfer or disposal was for fair market value. All transactions of \$5,000 or more occurring within a 12-month period shall be treated as a single transaction. These dollar amounts would be increased, beginning with 2007, from year to year based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest \$1,000 in the case of the \$100,000

number and to the nearest \$100 in the case of the \$5,000 number.

Applications or recertification forms shall include a statement that designates the state as the remainder beneficiary under such an annuity or similar financial instrument, subject to the following provisions:

- (A) For institutionalized individuals who receive certain Medicaid-covered long-term care services, the state would become the remainder beneficiary in the first position of an annuity (in which the individual has an interest) for the total amount paid by Medicaid on behalf of the individual. This provision would not apply when a spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) is a named beneficiary;
- (B) In the case of disclosure concerning an annuity, the state would notify the annuity's issuer of the state's right as a preferred remainder beneficiary in the annuity for Medicaid services furnished to the individual. This provision would not prevent the issuer from notifying persons with any other remainder of the state's interest in the remainder;
- (C) The state may require an issuer to notify when there is a change in the amount of income or principal being withdrawn from the amount being withdrawn at the time of the most recent disclosure, as specified above. A state would take such information into account when determining the amount of the state's obligations for Medicaid or the individual's eligibility. Such a change in amount would be deemed as a transfer of an asset for less than fair market value unless the individual demonstrates, to the state's satisfaction, that the asset transfer was for fair market value.

The Secretary may provide guidance to states on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

Section 3112 would apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment.

Section 3113. Application of "income-first" rule in applying community spouse's income before assets in providing support of community spouse.

Current Law

Current law includes provisions to protect a spouse whose husband or wife seeks Medicaid coverage for long-term care services.

Regarding income, current law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, section 1924(d) of the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance (MMMNA) to meet basic monthly needs. If the community spouse's monthly income amount is less than the MMMNA (or a higher amount per court order), the institutionalized spouse *may* choose to transfer an amount of his or her

income to make up for the shortfall. Within Federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no greater than \$2,377.50 per month, and no less than \$1,561.25 per month in 2005.

Regarding assets, Federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource allowance (CSRA). Federal requirements specify that this amount may be no greater than \$95,100 and no less than \$19,020 in total countable assets in 2005. If the community spouse's assets are less than the state-specified maximum, then the Medicaid beneficiary *must* transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets are supposed to be depleted before the applicant can qualify for Medicaid.

States have some flexibility in the way they apply these rules. In allocating income and resources between spouses, states have employed two divergent methods. Under the "income-first" method, the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet the MMMNA; the remainder, if any, is applied to the institutionalized spouse's cost of care. Under this method, the assets of an institutionalized spouse (e.g., an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse *unless* the income transferred by the institutionalized spouse would not enable the community spouse's total monthly income to reach the MMMNA (or a higher amount per court order).

In contrast, under the other method, known as the "resources-first" method, the couple's resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income, including income generated by the CSRA, meets the community spouse's minimum monthly maintenance needs allowance. Additional income from the institutionalized spouse that may be, but has not been, made available for the community spouse is used toward the cost of care for the institutionalized spouse. Applying the "resources-first" method, courts have allowed institutionalized spouses to transfer resources worth hundreds of thousands of dollars upon an ostensible showing such resources have limited income-producing potential.

Explanation of Provision

Section 3113 would amend section 1924(d) of the Social Security Act to require that any transfer or allocation made from an institutionalized spouse to meet an income need of a community spouse be first made from income of the institutionalized spouse, thus codifying the "income-first" method. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated.

Section 3113 would apply to transfers and allocations made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Section 3114. Disqualification for long-term care assistance for individuals with substantial home equity.

Current Law

Medicaid excludes the entire value of an applicant's home, without limit, when determining financial eligibility for long-term care assistance. Thus, a home value of one million dollars (\$1,000,000), five million dollars (\$5,000,000), or even ten million dollars (\$10,000,000) does not affect an applicant's access to taxpayer-financed care. A home is defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence.

Explanation of Provision

Section 3114 would amend section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, those individuals with an equity interest in their home of greater than half-a-million dollars (\$500,000). This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers rounded to the nearest \$1,000.

Section 3114 would not apply to individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home. The Secretary would establish a process to waive application of this provision for demonstrated cases of hardship. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

In addition, section 3114 would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Section 3115. Enforceability of continuing care retirement communities (CCRC) and life care community admission contracts.

Current Law

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. CCRCs were developed, in large part, in response to an interest among many elderly persons to age-in-place. CCRCs are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Under current law, section 1919(c)(5)(A)(i)(II) of the Social Security Act prohibits a Medicaid-certified nursing facility from requiring oral or written

assurance that such individuals are not eligible for, or will not apply for, benefits under Medicaid or Medicare. Courts have construed this language to invalidate contract provisions, mutually agreed to by applicants and communities that provide residents spend declared resources before applying for taxpayer-financed care.

Explanation of Provision

Section 3115 would amend section 1919(c)(5)(A)(i)(II) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for a community spouse), declared for the purposes of admission, on their care before they apply for Medicaid.

This section would also amend section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resource, and thus available (subject to a community spouse resource allowance if applicable) to the applicant, for purposes of the Medicaid eligibility determination if the following conditions are met:

- (A) the individual would have the ability to use the entrance fee, or the contract provides that the entrance fee could be used, to pay for care should other resources or income of the individual be insufficient to pay for care;
- (B) the individual would be eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contract and leaves the community; and
- (C) the entrance fee does not confer an ownership interest in the CCRC or life care community.

Section 3121. State option for alternative Medicaid premiums and cost sharing.

Current Law

State Medicaid programs may require that certain beneficiaries pay deductibles, co-payments or other service-related cost sharing amounts, although there are limits on the amounts that states can impose, the beneficiary groups that can be required to pay, and the services for which cost-sharing can be charged. Generally, states are precluded from imposing any meaningful cost sharing on Medicaid beneficiaries because Section 1916(e) of the Social Security Act prohibits providers from denying care or services to a beneficiary on account of the beneficiaries' inability to pay any deduction, cost sharing, or similar charge.

Medicaid specifically prohibits the imposition of any cost sharing on some groups of beneficiaries, unless the prohibitions are waived under an approved research and demonstration waiver. All cost-sharing related to the delivery of health services is prohibited for children under 18 years of age, and pregnant women for any services that relate to the pregnancy or

any related condition that may complicate the pregnancy. In addition, cost sharing cannot be charged for services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual was required to spend most of their income for medical care; services furnished to individuals receiving hospice care; emergency services; and family planning services and supplies.

Subject to the prior limitations, Medicaid programs are allowed to establish “nominal” service-related cost-sharing requirements. Nominal amounts are defined in regulations (42 CFR 447.54) and are generally between \$0.50 and \$3, depending on the cost of the service provided. For working individuals with disabilities who qualify for Medicaid under the Balanced Budget Act of 1997 (BBA97) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) pathways, service-related cost-sharing charges may be required that exceed nominal amounts as long as they set on a sliding scale based on income. Premiums and enrollment fees are generally prohibited under Medicaid, except in limited circumstances for specified groups.

Explanation of Provision

While current law allows for cost-sharing, there is no authority by either the Secretary or the state to be able to enforce it. Section 3121 would allow states for the first time to choose to impose enforceable premiums and cost-sharing for certain groups of individuals for services. The intent of the provision is to encourage beneficiaries to have greater awareness of the costs of their health care and create incentives for the utilization of more appropriate and cost effective treatments. Examples include creating financial incentives for the use of lower cost generic medications, beneficiaries receiving primary care through health clinics or physicians and participating in disease management programs. Under this provision, premiums and cost-sharing would be allowed to vary among classes or groups of individuals and types of service, including through the use of tiered cost-sharing for prescription drugs.

The bill contains several limitations, which are intended to protect the most vulnerable Medicaid beneficiaries from any adverse consequences as a result of these new policies. The first limitation is income based. Medicaid beneficiaries with family incomes that do not exceed 100% of the FPL could only be charged nominal amounts for cost-sharing. In addition, the total amount of cost-sharing for all beneficiaries in a family with income below 100% could not exceed 5% of the total family income for the year. Beneficiaries with family income above 100% of FPL could face higher cost sharing amounts, but the total amount could still not exceed 5%.

The bill continues to exempt certain types of beneficiaries (subject to the drug and hospital cost sharing policies described below) and services from the new cost sharing policy. These beneficiaries include (1) mandatory Medicaid services furnished to individuals under 18 years of age and individuals receiving adoption or foster care assistance under part E of title IV without regard to their age; (2) preventive care and immunizations provided to all children under 18 years of age; (3) services

furnished to pregnant women if such services relate to pregnancy or to any other medical condition which could complicate the pregnancy; (4) services furnished to a terminally ill individual who is receiving hospice care; (5) services furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution if such individual is required as a condition of receiving services to spend down for the cost of medical care all but a minimal amount of the individual's income for personal needs; (6) emergency services; and, (7) family planning services and supplies. States, at their option, may also exempt additional classes of individuals or services from cost-sharing.

Section 3121 would direct the Secretary to adjust the current "nominal" cost-sharing amounts, which have remained unchanged since 1982. Beginning on January 1, 2006, nominal cost sharing amounts will gradually increase over three years, so that the amounts will equal \$5 in 2008. Other nominal amounts would be increased by a proportional amount over the same period. Beginning in 2009, all nominal amounts would be increased by the annual percentage increase in the medical care component of the consumer price index for all urban consumers and would be rounded up in an appropriate manner.

States would specify the manner that family income would be determined and the income disregarded for cost-sharing purposes. Family income must be determined for such period and at such intervals (periodicity) as the state specifics. The cost-sharing provisions would not prevent states from further limiting cost sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.

Section 3121 would also allow states to condition the provision of medical assistance on the payment of premiums, and to terminate eligibility for medical assistance on the basis of failure to pay a premium if that failure continues for at least 60 days. States may also waive premium payments in cases where such payments would be an undue hardship. The provision would allow states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition for the provision of care or services. Providers would also be allowed to reduce or waive cost-sharing amounts. The provision would allow states to implement these new provisions regarding cost-sharing on or after January 1, 2006.

Finally, under section 3121, the Government Accountability Office (GAO) would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services. The report would be required to be submitted to Congress no later than January 1, 2008.

Section 3122. Special rules for cost sharing for prescription drugs.

Current Law

Cost-sharing for outpatient prescription drugs follows the rules described above for all cost-sharing amounts. While some states may require cost-sharing amounts that are slightly lower for generic drugs or

for drugs listed on a preferred drug list, the application of Section 1916(e) limits the effectiveness of such efforts.

Explanation of Provision

Section 3122 would allow states to impose cost-sharing amounts in order to create financial incentives for beneficiaries to use clinically appropriate, lower cost medications. Under this option, states may impose higher cost-sharing amounts for non-preferred drugs within a class, and waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class in order to encourage the use of lower cost drugs.

Total amounts of cost-sharing for non-preferred drugs would be limited by the income level of the beneficiary. For those individuals with family income below 100% of FPL, nominal cost sharing would apply (with no cost sharing allowed for preferred drugs). For those with family income at or above 100% but below 150% of FPL, the cost sharing would be capped at two times the applicable nominal amount, and for those with income equal to or exceeding 150% of FPL, cost sharing would be capped at three times the applicable nominal amount. In addition, states in establishing lists of preferred drug must include all drugs currently designated as preferred drugs under the TRICARE pharmacy benefit program. Similarly, states could not impose cost-sharing on Medicaid beneficiaries that exceed the TRICARE standards for cost-sharing.

In cases in which a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product. This provision would not prevent states from excluding specified drugs or classes of drugs from these special cost-sharing rules. Finally, states would be prohibited from implementing these special cost-sharing rules for prescription drugs unless the state has instituted a system for prior authorization and related appeals processes for outpatient prescription drugs. The provision would become effective for cost-sharing imposed for items and services furnished on or after October 1, 2006.

Section 3123. Emergency room copayments for Non-Emergency care.

Current Law

States may request and receive approval for a waiver of nominal cost sharing amounts for emergency room services provided for non-emergencies. This waiver authority, in section 1916(a)(3) and (b)(3), allows states to impose cost-sharing amounts of up to twice nominal levels for outpatient services received at a hospital emergency room if the services are not emergency services. States may impose such amounts if they have established, to the satisfaction of the Secretary, that individuals eligible for services under the plan have available and accessible to them alternative sources of non-emergency, outpatient services.

Explanation of Provision

Section 3123 would allow states, thru state plan amendments, the option to impose cost-sharing on individuals seeking treatment in hospital emergency rooms for non-emergency services. The intent of the section is to create a disincentive to discourage beneficiaries from using hospital emergency rooms to obtain primary and other forms of non-emergency care. In the course of its examination of this issue, the Committee found numerous studies that highlight the frequency with which some individuals seek treatment for non-emergency services in hospital emergency rooms. This imposes significantly increased costs on providers, diverts needed resources away from those truly needing emergency care, and denies these individuals the opportunity to benefit from coordinated primary care and disease management programs that they might otherwise receive from a physician or health center.

Under the proposal, states would be allowed to amend their state plans to apply increased cost-sharing only if the individual seeking care has actually available and accessible to them alternate non-emergency providers for needed services. In addition, before being able to charge a co-payment; the physician or hospital must inform the beneficiary after the appropriate screening assessment, but before the non-emergency services are provided that the hospital can require the increased cost-sharing amount; the name and location of the alternative non-emergency services provider that is actually accessible and available; that the alternate provider can provide services without the co-payment charged in the emergency room; and that the hospital can provide a referral to coordinate scheduling the treatment.

For individuals in families with income below 100% of FPL, the increased cost sharing amount for non-emergency services provided in a hospital emergency department cannot exceed twice the nominal amounts. Individuals who are otherwise exempt from cost-sharing under proposed section 1916A(b)(4) may be required to pay a co-payment for non-emergency services provided in a hospital emergency department, but the required payment could not exceed a nominal amount. In addition, aggregate caps on cost-sharing (in terms of nominal amounts and maximum cost-sharing based on the specified percentage of family income identified above) would still apply.

Nothing in this provision would be intended to limit a hospital's obligations to screen and stabilize an emergency medical condition (as defined for Medicare purposes); or to modify any obligations under a Federal or state prudent-layperson standard with respect to payment or coverage of emergency services provided by managed care organizations. Hospitals and physicians making decisions regarding the applicable cost-sharing amount would be protected from liability in a civil action or proceeding for such a determination absent a finding of clear and convincing evidence of gross negligence. This section does not affect any liability based on examination and treatment of emergency medical conditions and women in labor, as defined in Medicare statute, nor otherwise applicable provisions regarding the delivery of services or failure to provide care under state law.

Additionally, section 3122 would require the Secretary to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. It also authorizes and appropriates \$100 million for paying such providers for the 4-year period beginning with 2006, among those states that file an application for funds in such a manner as the Secretary specifies. The Secretary would be required to give a preference to states that establish or provide for alternate non-emergency services providers or networks of such providers that serve rural or underserved areas where beneficiaries may not have regular access to primary care providers, or in partnership with local community hospitals. The provision would be effective upon the date of enactment.

Section 3124. Use of benchmark benefit packages.

Current Law

Medicaid's current benefits package is typically very generous, especially when compared with the actuarial value of benefits provided through private health plans, state employee plans and Federal Employee Health Benefit Plans that are available for Members of Congress, their staff and other Federal employees. Federal law requires states to provide certain benefits under their Medicaid programs. States may also elect to provide additional, so called optional benefits (which must be generally available to all Medicaid beneficiaries). In general, each service must be sufficient in amount, duration and scope to reasonably achieve its purpose. With certain exceptions, the amount, duration and scope of benefits must be the same statewide. And with certain exceptions, beneficiaries must have freedom of choice among health care providers or managed care entities participating in Medicaid.

The benefits that states provide to Medicaid beneficiaries may currently differ, depending on whether the individual is categorically eligible versus medically needy. "Medically needy" groups include individuals meeting the same categorical requirements as the categorically needy (i.e., they are families with children, aged, disabled, pregnant, etc.). Medical expenses (if any) may be subtracted from income in determining financial eligibility for medically needy individuals. For nearly all categorically needy groups, medical expenses are not considered when determining financial eligibility for Medicaid.

Benefits identified in Federal statute and regulations include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (e.g., physicians, inpatient hospital services) whose array of services are designated as coverable under Medicaid. Still other benefits define specific types of service (e.g., family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid.

Examples of benefits that are *mandatory* for most Medicaid groups include (1) inpatient hospital services; (2) services provided by Federally qualified health centers; (3) laboratory and x-ray services; (4) physician

services; (5) early and periodic screening, diagnostic and treatment services for individuals under 21; (6) pregnancy-related services; (7) nursing facility services for individuals age 21 and over; and, (8) home health care for those entitled to nursing home care. Examples of *optional* benefits for most Medicaid groups that are offered by many states include prescription drugs, routine dental care, and physical therapy.

In contrast, the State Children's Health Insurance Program (SCHIP) provides states with greater flexibility in designing the appropriate benefits package. The SCHIP model has been very successful, and has allowed states to provide health coverage for up to 5 million previously uninsured children since its inception in 1997. Under SCHIP, states may enroll targeted low-income children in Medicaid (sometimes called an SCHIP Medicaid expansion), create a new separate state program, or devise a combination of both approaches.

Generally, states that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark-equivalent coverage, or, (3) any other health benefits plan that the Secretary determines will provide appropriate coverage to the targeted population of uninsured children. A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and, (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category," including (1) inpatient and outpatient hospital services, (2) physicians' surgical and medical services, (3) lab and x-ray services, and, (4) well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category," including (1) prescription drugs, (2) mental health services, (3) vision services, and (4) hearing services. The actuarial value of benchmark benefit packages, coverage offered under the state SCHIP plan, and coverage of any categories of additional services must be established in an actuarial report prepared by a member of the American Academy of Actuaries.

Explanation of Provision

Section 3124 would give states the ability to modify the Medicaid benefits package for certain groups of beneficiaries. These modifications would be similar to the modified benefits that many states currently provide through their SCHIP programs. States would not be required to adopt any of the changes, but merely gain additional flexibility in designing a benefits package that best fits the needs of their Medicaid beneficiaries.

This section would allow states, through a state plan amendment, to provide Medicaid benefits to certain groups of beneficiaries through benchmark coverage or benchmark equivalent coverage. States that offer benchmark or benchmark equivalent coverage could also choose to provide wrap-around or additional benefits, as the state may specify. Premium payments for benchmark or benchmark equivalent coverage would be treated as medical assistance, and thus would be eligible for Federal financial participation (i.e., the Federal government would share in the costs of these premium payments).

States would be able to require that a “full-benefit eligible individual,” within a group of such individuals, obtain services through enrollment in benchmark or benchmark equivalent coverage. A full-benefit eligible individual means (for a given state and month) an individual who is determined eligible for all services covered for the categorically needy, or under any other category of eligibility for all such services, as determined by the Secretary. The definition of full-benefit eligible individual *excludes* persons who are: (1) medically needy, (2) categorically needy individuals in certain states who are required to pay for medical expenses from their income until their remaining net income meets SSI financial standards in effect in 1972, and, (3) other individuals who qualify for Medicaid when costs incurred for medical expenses or other remedial care are subtracted from income to meet financial eligibility requirements (also known as spend-down populations).

States would also be required to exempt certain populations and services from the application of this section. These include: (1) mandatory pregnant women and children, (2) dual eligibles (i.e., Medicaid beneficiaries also entitled to benefits under Medicare), (3) terminally ill hospice patients receiving Medicaid hospice services, (4) individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF-MR), or other medical institution, when such an individual is required as a condition of receiving institutional care, to pay for costs of medical care except for a minimal amount retained from their income for personal needs, (5) individuals who are medically frail or who have special medical needs, as identified in accordance with regulations of the Secretary, and, (6) individuals who qualify for Medicaid long-term care services (i.e., nursing facility services, a level of care in any institutional equivalent to nursing facility services, home and community-based waiver services, home health services, home and community care for functionally disabled elderly individuals, personal care, and other optional long-term care services offered by the state).

This section would also modify the current definition of benchmark dental coverage to include dental benefits coverage that is equivalent to or better than the dental coverage offered under the dental benefit plan that covers the greatest number of individuals in the state (exclusive of Medicaid). Section 3124 also requires that the benchmark or benchmark equivalent coverage provides access to services provided by rural health clinics or Federally qualified health centers.

Section 3125. State option to establish Non-Emergency medical transportation program.

Current Law

Although there is no explicit reference to transportation in Federal Medicaid law, Federal regulations require states to ensure necessary transportation for recipients to and from providers and to describe the methods that they will use to meet this requirement in their Medicaid state plan. States may choose whether to provide transportation as an optional Medicaid service or claim it as an administrative expense.

If a state chooses to provide transportation as an optional Medicaid service, the state receives matching payments from the Federal government, determined using the Federal medical assistance percentage (FMAP). Under this option, states must meet a number of Federal requirements that apply to all Medicaid services (e.g., enrollees must have freedom to choose among qualified providers) unless they have an approved waiver from the Centers for Medicare and Medicaid Services (CMS). The state may only receive matching payments at its FMAP rate if the provider actually supplying the service receives payment directly from the state. Other arrangements (e.g., payment to a broker who manages and pays transportation providers) must be claimed as an administrative expense.

If a state chooses to claim transportation as an administrative expense, the state is reimbursed by a 50% match rate, which is lower than the FMAP in many states. However, states may be willing to trade lower Federal reimbursement for flexibility under this option, since there are fewer Federal requirements that must be met.

Currently, it is estimated that about four million Medicaid recipients, many of them in rural areas, use non-emergency, medical transportation (NEMT) to access essential medical services such as doctors' visits and kidney dialysis.

The HHS Inspector General has identified "brokerage" agreements (under which state Medicaid agencies contract with public or private non-profit or for-profit transportation providers to be the sole provider of NEMT for a geographical area) as a strategy to reduce fraud and abuse. Brokerage agreements facilitate strict screening and re-screening at the time of the trip for eligibility and reconciliation of trips with payments for medical services.

United We Ride, the Federal Interagency Coordinating Council on Access and Mobility, created by on February 24, 2004 by executive order of President George W. Bush, also identified brokerage agreements as a strategy to save Medicaid dollars. A recent United We Ride report found, following the institution of a brokerage agreement for NEMT in Georgia, "In the first year, transportation costs were cut in half and continued to decline by 30 percent over the next two years." Under current law and Federal regulations, states wanting to establish transportation brokerages must use Medicaid administrative funds or obtain section 1915 (b) freedom of choice waivers, which must be renewed every three years.

Explanation of Provision

Section 3125 authorizes a new optional service, non-emergency medical transportation brokerage program. States would have the option to establish brokerage agreements without obtaining section 1915 (b) freedom of choice waivers or using administrative funds. This will provide a more cost-effective form of transportation for individuals eligible for Medicaid who need access to medical care and have no other means of transportation.

Section 3125 also establishes standards for brokerage contracts including a competitive bidding process based on a state's evaluation of the broker's experience, performance, references, resources, qualifications and costs. Brokers must have oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified competent and courteous. This section also requires a report to Congress by the HHS Inspector General by January 1, 2007 on the implementation of this provision.

Section 3126. Exempting women covered under breast or cervical cancer program.

Current Law

Women with breast and cervical cancer are provided eligibility for Medicaid services under Section 1902(aa) of the Social Security Act.

Explanation of Provision

Section 3126 would exempt individuals who are eligible under Section 1902(aa) from the application of any other sections of this proposal.

Section 3131 Expanded access to home and Community-Based services for the elderly and disabled.

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of Title XIX of the Social Security Act give states the flexibility to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., elderly individuals) or a specific geographic region, and limit the number of waiver participants usually on account of cost constraints. This has resulted in long waiting lists for the elderly, disabled, and MR/DD populations in many states.

Approval for a HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law (hospital, nursing facility or ICF-MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

A HCBS waiver is generally approved for a 3 or 5-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS). In July 2003, there were 275 HCBS waivers nationwide in all states (except Arizona which offers HCBS services under a Section 1115 waiver).

Explanation of Provision

Section 3131 would allow states to cover a broad range of home and community-based services (HCBS) as an optional benefit under the state Medicaid plan *without* requiring a waiver. States would be able to define which HCBS services will be covered and could include any service authorized by Federal law for existing HCBS waiver programs (as defined in Section 1915(c)(4)(B) of the Social Security Act).

To qualify for this benefit the individual must meet the following criteria: (1) age 65 or older or disabled (as defined under the Medicaid state plan) or are persons with a developmental disability, mental retardation or a related condition; (2) have had a determination that, but for the provision of such services, the individual would require the level of care provided in a hospital, nursing facility or ICF-MR (the cost of which could be reimbursed under Medicaid); and, (3) meet the Medicaid eligibility standards in effect in the state (which may include an approved Medicaid waiver) as of the date of enactment of this provision.

A state would not be required to comply with existing Medicaid requirements regarding the statewide availability of the service, the comparability of services, and the income and resource rules applicable in the community. A state may also limit the number of individuals who are eligible for services, establish waiting lists for the receipt of these services, and limit the amount, duration, and scope of services.

Section 3131 would be effective for home and community-based services furnished on or after October 1, 2006.

Section 3132. Optional choice of self-directed personal assistance services (cash and counseling).

Current Law

Under current law, state Medicaid programs offer several types of long-term care services to individuals who, because of disability or chronic illness, need assistance with activities such as eating, bathing, and dressing. Medicaid programs have the option of covering personal care services and may also cover a broad set of other services through a home and community-based (HCBS) waiver authorized under Section 1915(c) of the Social Security Act. To qualify for a HCBS waiver, the

individual must require the level of care of a hospital, nursing facility or intermediate care facility for persons with mental retardation.

Traditionally, Medicaid personal care and other related services have been provided to individuals through local public or private agencies. However, in the last decade, Medicaid beneficiaries with disabilities or chronic conditions and Federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as “self-directed” or “consumer-directed” programs. The specific elements that a Medicaid beneficiary can control vary widely depending upon the state and the type of service covered. Currently, Medicaid law allows certain types of self-directed programs to be implemented through the normal Medicaid state plan and HCBS waiver process. Other types of self-directed programs, such as “Cash and Counseling” require a research and demonstration waiver under Section 1115 of the Social Security Act. As well, CMS has created an “Independence Plus” template to facilitate state waiver requests by outlining the required elements of a waiver application and by providing technical assistance on key features of a self-directed program.

Explanation of Provision

Section 3132 would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The Secretary must not approve a state’s self-directed personal assistance services program unless the state assures that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and that financial accountability exists for funds expended for these services.

The state must also evaluate the need for personal care under the Medicaid state plan or personal services under a HCBS waiver for individuals who (1) are entitled to Medicaid personal care under the state plan or receive HCBS waiver services; (2) may require self-directed personal assistance services; and, (3) may be eligible for self-directed personal assistance services. If covered by the state and at the choice of the individual, those who are likely to require personal care or HCBS waiver services must be informed of the feasible alternatives in the provision of Medicaid personal care services or personal assistance services under a HCBS waiver. The state must also provide a support system that ensures participants in the program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets.

Additional counseling and management support may be provided at the request of the participant.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Under this section, the term “self-directed personal assistance services” means personal care and related services, or HCBS waiver services that are provided to an eligible participant. Individuals participating in such services will be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services.

At the election of the state, a participant will be allowed to (1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and, (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance. This provision will apply to services furnished on or after January 1, 2006.

Section 3133. Expansion of State long-term care partnership program.

Current Law

Under Medicaid’s long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary’s death when Medicaid estate recovery is generally applied.

Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) allows states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. Except for Iowa, all of these states have implemented partnership programs.

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. HIPAA also includes requirements that tax-qualified policies comply with

consumer protections regarding the delivery of policies, information on denials of claims, and disclosure.

Explanation of Provision

Section 3133 would amend section 1917(b)(1)(C)(ii) of the Social Security Act to allow additional groups of individuals in states with state plan amendments approved *after* May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. The term “Qualified State LTC Insurance Partnership,” would mean a Medicaid State plan amendment that provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(A) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. (In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged);

(B) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary;

(C) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection;

(D) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department’s role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(E) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary’s regulations (promulgated after consultation with the states), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines appropriate to the administration of such partnerships;

(F) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Secretary, as appropriate, would provide copies of the state reports to the state involved and would promote the education of consumers regarding qualified state long-term care insurance partnerships. In addition, in consultation with other appropriate Federal

agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, the Secretary would develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary may develop, in consultation with the states and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships.

With respect to policy exchanges, existing policy holders will be able to exchange existing policies for Partnership policies in accordance with policy provisions and state law after a State's plan amendment is effective.

A state plan amendment that provides for a qualified state long-term care insurance partnership would be effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

Section 3134. Health opportunity accounts.

Current Law

No provision exists in current law.

Explanation of Provision

Inspired by the growing popularity and success of health savings accounts (HSAs) created in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, health opportunity accounts are intended to give participants meaningful opportunities to participate in the health care marketplace with greater choice of providers than otherwise available in the Medicaid program.

Section 3134 would require the Secretary to establish a demonstration program within Medicaid for health opportunity accounts providing alternative benefits beginning January 1, 2006. During the first five years, the Secretary would be able to approve no more than ten state demonstration programs; after such period, a state demonstration program would be able to be extended or made permanent unless the Secretary finds it has been unsuccessful, taking into account the cost-effectiveness, quality of care, and other criteria. After such period, other states would be allowed to implement state demonstration programs unless the Secretary finds that all state demonstration programs have been unsuccessful based on those criteria.

Approved demonstration programs would create patient awareness of the high cost of medical care, provide incentives for them to seek

preventive care, reduce inappropriate use of health care, enable patients to take responsibility for health outcomes, provide enrollment counselors and ongoing education activities, provide that transactions can be conducted electronically and without cash, and provide access to negotiated provider payment rates.

Individual enrollment would be voluntary and effective for 12 months, though they would be permitted to be extended for an additional 12-month periods with the consent of an individual. The Secretary would be authorized to grant hardship exceptions to allow enrollees to end participation at any time including the initial 12-month period.

A state demonstration program would be required to specify eligible population groups. During the initial five-year period, a program would not be permitted to include individuals who are 65 years of age or older, individuals who are disabled, individuals who are eligible for Medicaid because they are (or were within the previous 60 days) pregnant, and individuals who have been eligible for Medicaid for a continuous period of less than 3 months. In addition, a demonstration project would not include pregnant women or children under 18 years of age required to be covered under a state plan, individuals entitled to Medicare, terminally ill patients receiving hospice care under Medicaid, patients in institutions if they are required (as a condition of receiving services under the state plan) to spend all but a minimal amount of their income for medical costs, individuals who are medically frail or have special medical needs (according to regulations of the Secretary), or individuals qualifying for long-term care services. States would be permitted to further limit eligibility.

Individuals enrolled in Medicaid managed care organizations (MCOs) would be permitted to participate in the demonstration program only if the state provides assurances that no more than 5% of the MCO enrollees would participate in the demonstration, that the proportion of MCO enrollees who would participate in the demonstration would not be not significantly disproportionate to the proportion of enrollees in other MCOs who would participate in the demonstration, and that the state would provide for an appropriate adjustment in the per capita payments to the MCO, taking into account likely differences in the use of health care.

Alternative benefits would be required to consist, at a minimum, of contributions to health opportunity accounts and, after an annual deductible is met, coverage for medical expenses in a year for items and services covered under the existing Medicaid state plan (including such a plan operating under the Section 1115 waiver authority). Nothing would prevent a state from providing coverage for preventive care without applying the annual deductible.

The annual deductible under the state demonstration program would be required to be at least 100 percent but no more than 110 percent of the annualized amount of state contributions to the health opportunity account (including both state and Federal shares) determined without regard to the dollar amount by which such state contributions would be indexed for inflation every year after 2006.

Participants *not enrolled* in Medicaid MCOs would be able to obtain services covered under Medicaid from any provider participating under

Medicaid at the same payment rates that would be applicable if the deductible did not apply, or from any other provider at payment rates that do not exceed 125% of the rates that would be applicable to such services furnished by a participating provider if the deductible did not apply. Participants *enrolled* in Medicaid MCOs would be permitted to obtain demonstration project services from any MCO provider under such organization at payment rates that would be applicable if the deductible did not apply. The payment rates just described would be computed without regard to any Medicaid cost-sharing requirements that would otherwise be applicable under the Medicaid state plan.

States would be permitted to vary the amount of the deductible and the maximum out-of-pocket cost-sharing (the excess of the deductible over the balance in the health opportunity account) for a family (or an individual) according to family (or individual) income as long as higher income families (or individuals) are not favored over lower income families (or individuals). Employers would be permitted to provide coverage for health benefits consisting of coverage for medical services provided after taking account of the deductible.

Contributions to health opportunity accounts would be permitted to be made by the state or by other persons and entities, such as charitable organizations. States would be permitted to limit contributions once an account balance reaches a state-specified amount. State contributions to an account (including both state and Federal shares) generally would not be permitted to exceed \$2,500 for each adult family member and \$1,000 for each child; these amounts would be indexed for inflation every year after 2006. However, states would be permitted to contribute more for specified individuals if they provide assurances that contributions otherwise made to others would be reduced so that aggregate state contributions would not be increased. No Federal financial participation would be available with respect to contributions exceeding the general limits nor to contributions made by persons or entities other than a state.

In general, health opportunity accounts would be used to pay for health care expenditures as the state specifies, though in no case would they be used for expenses that are not deductible for tax purposes. States would be permitted to restrict payments to providers that are licensed or otherwise authorized under state law to provide an item or service, and they would be permitted to deny payments for providers found to have failed to meet quality standards or to have committed fraud or abuse. Payments would also be restricted for items and services states find are not medically appropriate or necessary. States would be required to provide for a method whereby account withdrawals are made using an electronic system; they would not be permitted to authorize cash withdrawals.

If an account holder becomes ineligible for Medicaid because of an increase in income or assets, no additional state contributions would be permitted to be made and the balance in the account attributable to state contributions (including both state and Federal shares) would be required to be reduced by 25%. (For purposes of accounting for such contributions, withdrawals would be required to first be attributed to contributions made by the state.) Generally, the account would be required to remain available under the same terms and conditions as if the

account holder remained eligible for Medicaid. However, withdrawals would also be permitted to be made to purchase health insurance (though the account holder would not be required to do so) and, at state option, for additional expenditures (such as for job training and tuition) as specified by the state and approved by the Secretary. Withdrawals for additional expenditures would be allowed only if the account holder has participated in the health opportunity account program for at least one year.

States would be permitted to coordinate the administration of health opportunity accounts through a third-party administrator, and reasonable expenditures for this shall be reimbursable to the state in the same manner as other Medicaid administrative expenditures. States would also be permitted to establish procedures to penalize or remove individuals from accounts if they make nonqualified withdrawals, and they would be permitted to recoup costs associated with those withdrawals.

Amounts in or contributed to a health opportunity account would not be permitted to be counted as income or assets for purposes of determining eligibility for Medicaid.

Section 3141. Increase in Medicaid payments to insular areas.

Section 3141 would provide annual increases for fiscal years 2006 and 2007 in the cap on Federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, American Samoa and Puerto Rico.

Under this section, Puerto Rico's Medicaid cap would be annually increased by \$12 million in fiscal years 2006 and 2007. The Virgin Islands and Guam would have their caps increased by \$2.5 million in fiscal year 2006 and \$5.0 million in fiscal year 2007. The Northern Marianas' cap would be increased by \$1 million in fiscal year 2006 and \$2 million in fiscal year 2007. American Samoa's cap would be increased by \$2.0 million in fiscal year 2006 and \$4 million in fiscal year 2007. For fiscal year 2008 and subsequent fiscal years, the total annual cap on Federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the fiscal year 2007 ceiling, as modified by this provision, by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics).

Section 3142. Managed care organization provider tax reform.

Section 3142 would close the loophole created by the separate classification of Medicaid Managed Care Organizations (MCO) for purposes of establishing permissible provider taxes. The proposal would expand the current list of providers to include all MCO's. To qualify for Federal reimbursement under the proposal, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCO's. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based.

This section would become effective at the beginning of fiscal year 2009 when states with taxes based on the current law MCO provider class would be reimbursed for up to 50% of taxes collected. At the beginning of fiscal year 2010, no Federal Medicaid reimbursement would be available for taxes collected based on the current law MCO provider class.

Section 3143. Medicaid transformation grants.

In an effort to help modernize the Medicaid program and to increase administrative efficiency and clinical outcomes for beneficiaries, section 3143 adds a new subsection (y) to Section 1903 of the Social Security Act authorizing “Medicaid Transformation Payments.” In addition to the normal Federal reimbursement received under 1903(a), the Secretary of Health and Human Services would provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Examples of innovative methods for which such funds may be used include: (1) methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs, (2) methods for improving rates of collection from estates of owed to Medicaid, and, (3) methods for reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, and (4) implementation of a medication risk management program as part of a drug use review program under section 1927(g).

Total payments under the new subsection (y) would equal and not exceed \$50 million in each of fiscal years 2007 and 2008. The Secretary would specify a method for allocating the funds among states. Payment to a state under subsection (y) would be made in the same manner as other payments under Section 1903(a), but there would be no requirement for state matching funds to receive such payment.

The committee recognizes the dramatic impact that the adoption of electronic medical records and electronic prescribing can have on reducing patient errors for the Medicaid population. Adoption of electronic medical records has been estimated to cost an average of \$33,000-\$44,000 per physician and health care facilities with high Medicaid populations are seeking assistance to set up these systems. Accordingly, the committee recommends that the Secretary focus the funding for the Medicaid Transformation Grants on county nursing homes, skilled nursing facilities, Federally qualified community health centers, Federally qualified community health center (and similar such facilities) and inter-city urban hospitals or any other health care provider or facility deemed to have a high Medicaid population by the Secretary.

Section 3144. Improved enforcement of documentation requirements.

Section 3144 amends the list of third parties named in Section 1902(a)(25) of the Social Security Act that states must take all reasonable measures to ascertain the legal liability of to include: (1) self-insured

plans, (2) pharmacy benefit managers, and, (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual.

A state would be required to provide assurances satisfactory to the Secretary that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (2) accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the state, and, (3) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided.

Section 3144 would be effective January 1, 2006, except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance with the Medicaid state plan requirements of this section.

Section 3145. Improved enforcement of documentation requirements.

In order to reduce the number of individuals receiving Medicaid benefits who are not lawfully in the United States, section 3145 adds a new subsection (a)(22) to Section 1903 of the Social Security Act to prohibit states from receiving Federal reimbursement for medical assistance provided under Medicaid to an individual who has not met the documentary requirements of a new subsection (y), as described below.

The new subsection (y) would require an individual declaring to be a citizen or national of the United States to present satisfactory documentary evidence of citizenship or nationality (as described below). The requirement would not apply to aliens who are eligible for Medicaid: (1) on the basis of being entitled or enrolled for benefits under Medicare (2) on the basis of receiving Supplemental Security Income benefits, or (3) such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

For purposes of the new subsection (y), satisfactory documentary evidence would include one of the following documents: (1) a United States passport; Form N-550 or N-570 (Certificate of Naturalization); (2) Form N-560 or N-561 (Certificate of United States Citizenship); or, (3) such other document that the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

Satisfactory documentary evidence would also include a document from each of the following lists: (1) a certificate of birth in the United States; (2) form FS-545 or Form DS-1350 (Certificate of Birth Abroad);

(3) form I-97 (United States Citizen Identification Card); (4) form FS-240 (Report of Birth Abroad of a Citizen of the United States); or, (5) Such other document as the Secretary may specify (excluding a document specified by the Secretary as described above) that provides proof of United States citizenship or nationality; and any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act; or any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

This section would apply to determinations of initial eligibility for Medicaid made on or after July 1, 2006, and to redeterminations made after such date in the case of individuals for whom the requirement of the new subsection (y) was not previously met.

Section 3146. Reforms of targeted case management.

Section 3146 would further define the Medicaid Targeted Case Management (TCM) benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another Federally-funded program.

Specifically, section 3146 would clarify that the TCM benefit includes the following: (1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; (2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; (3) referral and related activities to help an individual obtain needed services; and, (4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

Section 3146 would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would not include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would not cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the eligible individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this section would also specify that Federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

Section 3147. Emergency services furnished by non-contract providers for Medicaid managed care enrollees.

Section 3147 amend Section 1932(b)(2) of the Social Security Act to provide that any provider of emergency services that does not have in effect a contract with a Medicaid managed care plan must accept as payment in full the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) it could collect if the beneficiary received medical assistance other than through enrollment in a managed care plan.

Section 3148. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.

Section 3148 would disregard for computing the per capita income of a state any significantly disproportionate employer pension contribution when determining the Federal medical assistance percentage (FMAP) under Section 1905(b) of the Social Security Act beginning fiscal year 2006. A significantly disproportionate employer pension contribution is an employer contribution toward pensions allocated to such state for a period if the aggregate amount so allocated exceeds 50 percent of the total increase in personal income in that state for the period involved.

Section 3201. Targeted Medicaid relief for States affected by Hurricane Katrina.

Section 3201 provides that for items and services furnished during the period that begins on August 28, 2005, and ends on May 15, 2006, the FMAP would be 100% for providing medical assistance for such items under a Medicaid state plan to any individual residing in a Katrina impacted parish or county or to a Katrina Survivor. Costs directly attributable to all administrative activities that relate to the provision of such medical assistance would also be reimbursed at 100%. A Katrina impacted parish or county is any parish in the state of Louisiana, any county in the state of Mississippi, and any major disaster county in the state of Alabama.

During the period, the Federal reimbursement rate would be 100% for providing child health assistance under an SCHIP state plan to any individual residing in a Katrina impacted parish or county or to a Katrina Survivor, as well as for costs directly attributable to related administrative activities. For purposes of section 3201 (a), the provision would define a Katrina Survivor as an individual who, on any day during the week preceding August 28, 2005, had a primary residence in a major disaster parish or county (described in section 3201 (c)).

For purposes of section 3201 (a), the provision would define a major disaster parish or county as a parish of the state of Louisiana or a county of the state of Mississippi or Alabama for which a major disaster has been declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act as a result of Hurricane Katrina and which the President has determined, as of September 14, 2005, warrants individual assistance from the Federal government under such Act.

Section 3202. State high risk health insurance pool funding.

Section 3202 would amend the Public Health Service Act to reauthorize Federal funding for state high-risk health insurance pools for fiscal year 2006. For fiscal year 2006, the provision would provide \$90 million in appropriations for grants to states to be used to cover up the operating expenses of existing state high risk pools in accordance with existing statutory requirements.

Section 3203. Recomputation of HPSA, MUA, and MUP designations within Hurricane Katrina affected areas.

Section 3203 would require the Secretary to conduct a review of all Hurricane Katrina disaster areas and designate (as appropriate) these areas as either health professional shortage areas or medically underserved areas and also designate populations living there as medically underserved populations.

Section 3204. Waiver of certain requirements applicable to the provision of health care in areas impacted by Hurricane Katrina.

Section 3204 is a waiver of Certain Requirements Applicable to the Provision of Health Care in Areas Impacted by Hurricane Katrina.

Section 3205. FMAP hold harmless for Katrina impact.

Section 3205 requires that the Secretary, when computing the FMAP under section 1905(b) to disregard evacuees and income attributable to such evacuees, who were evacuated as a result of Hurricane Katrina, for the purposes of calculating the states' FMAP.

Section 3301. Hurricanes Katrina and Rita energy relief.

Section 3301 makes available to the Secretary of the Department of Health and Human Services an additional one-time only \$1 billion in LIHEAP funding. This \$1 billion is in addition to any other funds appropriated for LIHEAP for fiscal year 2006. These funds are regular funds and flow through the LIHEAP formula. Availability of the \$1 billion expires at the end of fiscal year 2006.

[Insert text here]

DISSENTING VIEWS

[Insert views here]